September 18, 2009

Beth Tanzman
Deputy Commissioner Department of Mental Health
108 Cherry Street PO Box 70
Burlington, VT 05402-0070

Dear Beth,

Attached are the answers to questions submitted by the Futures Review Committee. I hope that you find them in order and that they assist the review committee in their ongoing and very important deliberations. Please do not hesitate to contact me if there are further questions or elaborations that are sought. We have attached several documents including additional information regarding the IMD and our Visitors Policy. Additional information regarding 'medical clearance' is also available upon request, however we believe the answer to that question is addressed in this document.

I would like to add a 'thank you' to members of the review committee for your interest in our proposal and for your thoughtful questions, some of which are straight forward with straight forward answers. Some like the work we do and the people we serve are a bit more nuanced and require great thought. For those, rather than a final answer we hope we provided a direction for further conversation together.

Review Committee Questions:

1. *What is the anticipated impact of the proposed 16-bed program on the existing adult inpatient capacity at the Retreat?*

   As stated on page 4 of the RFP, we do not anticipate the additional 16-bed program having any impact on the current capacity. We will continue to offer a 21 bed co-occurring unit, a 24 bed acute care unit and our new LGBT unit. This new program and existing programs would fall either under our licensed capacity of 149 beds or under the licensed bed capacity of BMH. Either way we do not anticipate nor are we planning to reduce adult inpatient capacity. The physical capacity of the Retreat would also allow for this expansion. It would, as noted on page 4, require moving the co-occurring program to an adjacent building and require minor renovations.

2. *What relationship is envisioned between the proposed 16-bed program and the existing adult inpatient population at the Retreat?*

   Each of the existing inpatient programs are distinct clinical milieus designed to be self sufficient. Mental Health Workers, Nurses, Social Workers, TAS, Psychiatry and all ancillary staff are, however, crossed trained to work within all adult programs. As the needs/progress of an individual changes it is possible to share

programming, outdoor and cafeteria space. All adults in care will receive care based upon the same Recovery focused clinical philosophy.

3. *Given the legal requirement that care be provided in the least restrictive environment, as well as the State's policy of favoring voluntary care whenever possible, and the fact that the proposed program is specifically a high acuity, involuntary, and high security setting, how would the proposer ensure access to less restrictive and/or voluntary inpatient care when appropriate? What is the cost implication of this in that other units at the Retreat would remain subject to the IMD exclusion?*

   The Retreat supports the concept of voluntary treatment as always the first and best option. Involuntary care, given its uncertain outcomes and impact on the treatment alliance should be reserved for the most extreme emergent situations and ideally last only as long as it takes to ensure safety for the individual. All care is driven by the needs of the client and is conducted in relationship to his/her individualized Recovery Plan. Constant assessment of treatment goals, feedback from client, team members, State Care Management System in relationship to LOCUS and a consumer's Care Manager are all touch points to determine if the care being provided is effective, respectful and taking place within the proper environment. The unit itself is designed with a less stimulation area, a general area and a medically monitored area. The milieu, itself, is structured to be responsive to the individual needs of people. We were not envisioning individuals necessarily moving from program to program/floor to floor. However, we envision that as patients improve they will be able to take advantage of the off unit treatment resources of the Retreat just as occurs in our other units. We do not see the IMD issue as a barrier for patients in this program to be able to avail themselves of other retreat resources. In this regard we do not envision increasing costs to duplicate existing Retreat treatment resources. Additionally, we were planning on tightly coordinating our work with all other treatment programs/levels of care involved in the Futures Project. When an individual is ready for Second Spring, Meadowview or community care we would work with the client and the State team to affect that change. The other adult programs would continue serving their clients and the pay sources of those clients would remain 60% Medicare/Medicaid and 40% other.

4. *Please provide a more detailed description of the IMD issue, the alternative approaches to avoid the IMD classification referenced in your proposal, and your analysis of the likelihood that the proposed program would not be classified as an IMD. In addition, please describe your understanding of the implications if the proposed and existing programs were classified as IMDs.*

   Craig Miskovich, attorney from Downs, Rachlin and Martin will be addressing this question in a separate memo requested by Representative Fisher. I would point out that the work in this area falls under federal statute 42cfr and we are following the example set by the Carrier Foundation in New Jersey which

successfully created a distinct unit five years ago to address the IMD and has been approved by CMS for funding. Please see attachments from Craig Miskovich.

5. *Can you provide an on-site facility for court hearings?*

   Yes, there is ample space within the Retreat for this, either on the unit, in the Tyler building or other building on campus.

6. *Can you please identify travel time estimates between the Retreat and key referring population centers such as Burlington and Montpelier? Please describe how family visits and coordination with ongoing care system would be facilitated given the geographic location of the proposed program.*

   Travel time from Burlington is 2 ½ hours and from Montpelier 2 hours. All of Vermont's 14 counties are served by the Retreat. Coordination of care is done by phone, visits and we have the capacity for video conferencing. Based upon the frequency of family/community supports, arrangements can be made for over night housing at one of the Retreat's residential houses on campus or with a local hotel where we have discounted rates. We have also begun to explore, internally, the option of travel/gas stipends which we would want to discuss with the State Care management system. We work closely with designated agencies and multiple other community resources to assist family members with transportation in order to participate in treatment.

7. *The Retreat offers an impressive Speaker's bureau and CME program. Please provide the organization's policies on the relationship between pharmaceutical sponsorship and physician and medical practice at the Retreat.*

   There is no relationship between the Pharmaceutical Industry and the Continuing Education offerings at the Retreat. All contact with any Pharmaceutical representatives is closely monitored and limited. The last time that the Retreat offered a conference that involved funding from the Pharmaceutical Industry was 1997, and that was an unrestricted educational grant in which the Company did not have input into the content of the conference.
   The inpatient Retreat physicians never meet with pharmaceutical representatives. The outpatient doctors only meet with representatives at appointed times (never on a drop-in basis) and primarily to sign for samples for indigent patients.
   Also please note that the Retreat supported S. 48.

8. *Overall, how would you describe the financial health of the Brattleboro Retreat?*

   The Retreat has been serving the citizens of Vermont and the region for 175 years and has every intent of continuing our legacy of innovative and excellent specialty psychiatric care. With the recruitment of a new CEO two and a half years ago, the Retreat has been engaged in a strategic planning process that has included a focus on increasing its financial stability by creating efficiencies

wherever possible, preserving its unique specialty programming, re-negotiating its managed care/insurance company contracts, re-financing its long term bonds, expanding its market share, creating a successful philanthropic program and adding new and innovative services (Bridges, Uniform Service Workers and LGBT programs). Over the recent years we have experienced financial set-backs as is the case with many rural specialty care providers. However, we expect to have a positive operating margin by the first quarter of our fiscal year 2010 and to continue in the black going forward.

9. *Please describe the interplay envisioned between the two clusters (4-bed sub cluster and the 12-bed area).*

   There are actually three areas outlined in the drawings. They are formed for a general population, medical monitoring and reduced stimulation area. We see the interplay as strong or limited as the treatment needs of the individuals on the unit require. We do not envision segregating people. In fact we hope that those individuals having a more difficult time will have many opportunities to share programming with the general population as a way to both practice skills and learn from peers.

10. *Would you consider adding a second RN on the night shift?*

    Yes, If it was determined that the needs of the milieu would benefit from this staffing mix. Typically we already do this if medical/acuity issues occur. We currently have 11-7 "float" RN positions that we utilize for such situations. Our senior level nursing supervisors collaborate with charge nurses and staffing coordinators to assure that resources are available to meet needs 24/7.

11. *What would you do differently from current practice to manage higher acuity and zero-reject admission policy in the proposed program?*

    Over the course of the past several years, we think that all hospitals have seen an increase in the level of need/acuity of the people we serve. We have already taken steps on our Tyler 2 Acute Care Unit to address these issues. We believe that the design of the milieu we have presented creates an effective use of space to manage acuity. We have moved to a CPI model of care, the Orlando Nursing Model, created an area specific to less stimulation, involved ourselves extensively in a SAMSHA Grant to reduce seclusion and restraints and developed in conjunction with VP&A and others our Six Core Strategy/Trauma Model. We have learned that a higher, better trained level of staffing is required, as is a more structured milieu. This is one area where concerns regarding individual bathrooms as more of a risk to safety than a benefit came from. We have increased our level of medical management, re-organized our Access and Evaluation Department to

ensure better triage, front door assessments and coordination of care. We have also learned much from our working relationship with staff at VSH and all the other designated hospitals. We anticipate continuing this learning and improving via Performance Improvement Projects that continue to inform our clinical practice regarding the management of a safe treatment milieu.

12. *What are the visiting hours for the program and how flexible can you be about these? How would you be more inclusive of families including space for family visits? Attached Visitor Policy*

    Accommodations are made on a daily basis for families to be involved in treatment and visit when it is convenient and appropriate. We are always flexible and want families and significant others involved in care and planning

13. *What community resources and or step down services are needed for this program to succeed? Please respond both in the context of your immediate community and statewide.*

    The Social Work staff are constantly researching and identifying new resources in the different communities and advocating for the specific needs of each of our patients. In many instances, we have been able to develop resources creatively with designated agencies and additional supports. Therapeutic residences such as Second Spring and Meadowview are types of resources that need to be developed further to serve this population that in the past have been difficult to discharge back to their communities due to lack of resources and support.
    The proposed Care Management System will assist in moving patients through the different systems of care, identifying resources early and regular communication between often time multiple agencies that are assisting patients and their families.

14. *How will you coordinate with the ongoing community care system, esp. for service areas that are far from Brattleboro?*

    Currently the average length of stay for an adult at the Retreat is less than 10 days. Within that time frame coordination of care with communities throughout Vermont is an essential part of all treatment plans. The fact that the Futures Project has identified the establishment of a statewide care management system and is working towards an integrated I.T. system may, in some ways, make the coordination of care a state of the art process and better than what currently exists. We actually see this as one of the strong points of participating in this endeavor. We already have a system in place where social workers and the designated agencies have treatment team conferences via phone or in person within the first 48 hours of admission so that coordination of care and planning begin immediately. These team meetings include the case manager, therapist and other members of the treatment team from the designated agency and other community

agencies involved with a specific patient. We also have quarterly meetings with HCRS and the social work staff to review difficult cases, issues or concerns around coordination of care. We have periodically done this with other designated agencies but not on a regular basis because of distance and scheduling. Coordination of care even in communities that are far from the Retreat is something that we do well with and have a lot of experience with.
We involve VP&A and DMH when appropriate as well

15. *Please specify how you would meet the full psychiatric needs of patients with complex and medical conditions (e.g. the importance of psychiatric program milieu and how that could be met at Brattleboro Memorial Hospital).*

We currently meet those needs for a variety of people who come to the Retreat. Our medical clinic provides a complete physical and medical exam at the time of admission. This results in a medical plan of action for each individual. BMH serves as a partner in the triage and care of our patients who may require a higher level medical treatment than we provide through our medical clinic. We have internists from Brattleboro Primary Care who are on-call for immediate assessment of patients on our site. This has allowed us to monitor and treat ongoing medical issues and respond to emergent needs as well. One of the options for dealing with the IMD issue is to establish a more formal partnership with BMH which could expand the existing medical/psychiatric rounds for individuals on this unit.

16. *The proposal references significant safety issues with single bathrooms. Please provide more detail about what the safety issues are and the data on which this assertion is based. Also please discuss your assessment of balancing issues of safety and privacy.*

Individual bathrooms in patient bedrooms create places that an individual in severe distress might go when intent on self harm. The concern is not only for the patient who occupies the room but also a patient from another room could choose to go to a peer's room where the staff might be less likely to locate them. This has led, in other hospitals, to locking either the bathroom or even the patient's bedroom in order to optimize the continuity of safety checks and keep the community safe. It is safer and more dignified to support patient access to the multiple private patient bathrooms that are positioned on the main corridors. Therefore, we believe that a plan for individual bathrooms is a risk to safety and that our expectation of staff attention to the dignity and privacy of each patient creates the milieu of respect that every person who is a patient here deserves.

17. *Please describe how the proposed program would interact with the Meadowview program in development.*

We anticipate these two programs would interact in the same way that any of the programs contained within this new system of care would interact; shared trainings, staff supports, back-up for crisis, placement for referrals, etc. Specifically if an individual at Meadowview was in crisis and needed a higher level of care, for a brief time, we see it more clinically conducive for that person to be able to go to the Retreat. As with any programs that are in close proximity with each other we would want to monitor, again as part of a PI process to make sure that all admission to a higher level of care are needed rather than the higher level of care being seen as a simple solution to manage a difficult situation. For those instances when the admission is needed being close by would allow for staff from both programs to coordinate, share treatment meetings and ensure that the individual knew that all of his/her providers were working together for an appropriate resolution.

18. *How would the program manage different patient needs and groups (gender, acuity, diagnosis, behavior) within the proposed program?*

This is what we currently do in all of our inpatient, residential and partial programs. This is at the heart of Recovery Plans and addressing individualized needs. The program in consultation with the individual and their community team determines common goals shared by all clients on the unit such as ADLs, affect management, problem solving, etc. It then identifies goals specific to the individual. Programming, groups, activities, nursing plans, daily interventions, etc. are directed towards addressing those goals in common and the goals specific to the person. Measuring whether the interventions are helpful and how/why then dictates further action.

19. *The proposal does not explicitly say that the program will serve individuals referred from Courts for competency evaluations or from Corrections for acute treatment. Please be explicit regarding forensic admissions.*

The Retreat currently accepts patients for forensic assessments (competency evaluations), and also accepts patients coming from Corrections for acute treatment. We intend to continue to do so and to be a resource to the State of Vermont for these services.

20. *Please provide a more detailed timeline for resolution of outstanding issues and project development milestones.*

Completion of renovations for units would take 6-12 months. The other outstanding issue of the IMD will be determined by which of the approaches we take; the partnership with BMH or the Hospital within a Hospital model. Until it is determined which avenue it is difficult to lay out a specific plan of action, however, based upon conversations with the Carrier Foundation and the law firm used to support their work, the concept of a Hospital within a Hospital would

appear to be the more complicated of the two options. Our first choice would be to partner with BMH. The formal legal and administrative requirements would commence immediately given that both institutions have expressed a strong willingness to move forward to accomplish this joint venture.

21. *How will the program (both facility and treatment) reflect the different cultures of Vermont?*

    The cornerstone of any good program is that it is sensitive to the social, cultural, financial, gender, racial and ethnic identities of the people of Vermont. CMS and the Joint Commission along with all professional licensing and training organizations pay great attention to assuring that programs are sensitive and responsive to the people that they serve. The Retreat has long been a part of Vermont's culture and adheres above all to the standard that we care for our neighbor's wellbeing. Vermont is a state that has riches and poverty. It is a state that although dominated by Caucasians has seen an increase in non white populations in recent years. Vermont has its 'true Vermonters' and its 'flat landers', its city and country dwellers, and those of us who live on paved roads and those of us who fear mud season. We respect our diversity and cherish our similarities and want our lives and the lives of our families to be rich, safe and healthy. In short any program, at any level of care needs to listen to the needs of its population, respond to unique needs and build upon what we all have in common.

22. *How do you see this proposed program as part of the larger system to insure that every patient has a bed even if your program is at capacity?*

    We'll begin by saying that we hope we all do this better than we currently do. The beauty of this project is that as stakeholders, from providers to families to consumers on down the line, have agreed that we need to care for people in crisis better than we currently do. Wait times for emergent care, no beds in the middle of the night, difficulty moving within the system are all reasons that the Retreat, RRMC, Springfield Hospital and FAHC submitted proposals. We are all citizens of Vermont which means we all want to find a way to keep doors open for people in need. Having participated in the Care Management work group, it's clear that this question does not have an easy answer. We know that there is work underway to establish a more technologically advanced bed racking system. It appears that each of the RFP's submitted has paid particular attention to ensuring that the milieus of each hospital will be better equipped and trained to serve a higher level of acuity. The entire purpose of the Futures project was to create a 'system' of care. For those of us who have stayed with this work for the past six years this means being there for people when they need us.

23. *How would the required renovations be capitalized?*

As stated in the RFP, we would want to discuss with the state how they arrived at the proposed plan to be used with RRMC. If there is an existing plan that can garner support and perhaps be used by all hospitals there may be a way to have one plan going to the bond market. This is also a conversation we would want to have with DMH and the state in far greater detail than we have had the opportunity to do to date.

24. *Are there any statutory changes you feel would be necessary or important to the proposed program's success? (For instance. Non-emergency involuntary medication, admission of court ordered evaluations without physician order and retain in hospital post physician recommendation?)*

    We anticipate that the Retreat would need to be able to provide non-emergency involuntary medicine and would only do so under circumstances that would be in full compliance with the law and would protect the legal rights of the patients. The laws or regulations would have to be modified for us to do so. We do not believe that non-emergency involuntary medicine would have to be employed very frequently.

    In a similar vein the Brattleboro Retreat is not allowed currently by law to admit patients without a physician order, and retain a patient post physician recommendation. We would do so only if permitted by law, and do not believe that those approaches would need to be utilized frequently.

25. *How would you define acute care and how would the needs of patients who may stay for long periods of time be met?*

    Acute care is something that needs to happen in that moment and that *may* require the most intensive level of care. It may resolve quickly or need extended time. There is acute care because the individual's Recovery Plan needs work and there is acute care because the individual is new to the system and needs grounding in Recovery Planning. Whether it's a brief stay for stabilization or a longer stay based upon the need for safety and structure, engaging people around hope for the future, a plan that has purpose and meaning in their lives and that provides safety first is how we would approach anyone coming to the Retreat. In general breaking issues down into less formidable obstacles, having clear, agreed to measures of progress can help with longer stays.

    Acute care also means that the patient receives care and treatment for ongoing medical issues. Because the hospital stay is anticipated to be longer than typical inpatients stays (which average 10 days duration), we anticipate that we will serve the primary medical care needs of the patients, including immunizations if needed, dietary counseling if appropriate, attention to any medical illness, and all the functions that primary care physicians undertake. Our medical clinic performs these functions currently, and will continue to do so. In addition, we contract

with Brattleboro Primary Care to provide back-up service 24 hours per day, 7 days per week, and 52 weeks per year.

In a psychiatric sense acute care means attention to the evolving mental health needs of the patients. As a fully staffed inpatient unit we have nursing care available around the clock and psychiatric care daily. Treatment teams meet regularly. Thus, patients' care needs can be addressed rapidly and intelligently.

We modify our program offerings on a regular basis to assure that patients do not get the same offerings over and over during a long stay. We do this by including process groups, art and movement therapy, leisure activities, and music therapy. The therapeutic services department assures a rich and varying approach to treatment. We draw on expertise gleaned from programs throughout the Retreat, including DBT, chemical dependency services, recreation therapy, the Lesbian/Gay/Transgender/Bisexual program, and the Uniformed Service Workers program. We offer Therapeutic Animal Services, Yoga, Mindfulness, Spirituality, and myriad others throughout the Retreat, and can bring that expertise to bear when indicated.

26. *What will you require for medical clearance prior to admission and can you be flexible especially if a patient is refusing medical care or evaluation?*

We do not have rigid criteria for medical screening. We have reviewed the report from the State of Massachusetts concerning medical clearance, and agree with their general conclusion that the notion of medical clearance is patient specific, and needs to address the fact that the patient will be on a psychiatric unit where there are some limits to the medical complexity that can be handled. Thus we do not have a specific type of examination that we require prior to admission, nor do we require specific laboratory work to be completed prior to admission.

We have a guideline (which we would be happy to provide) outlining some of the medical conditions that we can safely handle on inpatient psychiatric units, and conditions that we cannot handle.

We also have a guideline for accepting admissions of intoxicated patients, which we would also be willing to share. In short, if the patient is otherwise medically stable, able to walk and talk, and whose blood alcohol concentration is dropping rather than rising, we will accept the patient for admission. We do not have a blood alcohol concentration above which we will not accept the patient, nor do we require a set of laboratory studies to be undertaken.

We are flexible about asking patients who refuse to have a physical examination and blood work done. We perform these functions within 24 hours of admission, but will keep the patient hospitalized even if he or she refuses them. We will keep trying to perform a physical and labs every day until the patient agrees.